

Attachment C: UNREIMBURSED MEDICAL, DENTAL & VISION CARE EXPENSES

Case Number: _____

Father's Name:

Father's share of all unreimbursed expenses listed on this sheet is:

Mother's Name:

Mother's share of all unreimbursed expenses listed on this sheet is:

Total: 100%

Date of Service (oldest-first)	Name of Health Care Provider	Total Amount of Bill	Amount of Bill Paid by Insurance or 3 rd Party	Amount of Bill Paid by Father	Amount of Bill Paid by Mother	Remaining Balance of Bill Due	Amount of Father's Remaining Responsibility	Amount of Mother's Remaining Responsibility
Totals for This Sheet		\$	\$	\$	\$	\$	\$	\$

Page ____ of ____